StoneRidge Chiropractic

107 South 1470 East Suite 102 St. George, UT 84790 Phone 435-652-4476 Fax 435-674-2408

Justin W. Salmon, DC - Brian T. Richey, DC - T. Brock Kesterson, DC

WELCOME TO OUR CLINIC

Please present your Insurance Cards (if applicable) to copy

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION

Please PRINT

Last Name: Date:

First Name: MI: Email:

Address: Gender: Marital Status:

☐ Male ☐ Minor ☐ Widowed

City: ☐ Female ☐ Married ☐ Single

State: ZIP: ☐ Divorced ☐ Separated

Home/Cell Phone:

Work Phone: Do you prefer to receive calls at:

Birth Date: Age: ☐ Home ☐ Cell ☐ Work

Your Employer: Occupation:

Spouse or Parent's Name:

Whom may we thank for referring you to us?

Person to contact in case of emergency? Phone:

Symptoms
Areas of complaint

Severity
Mild, Moderate, Severe

1._____

2._____

3._____

4._____

How did symptoms occur? _____

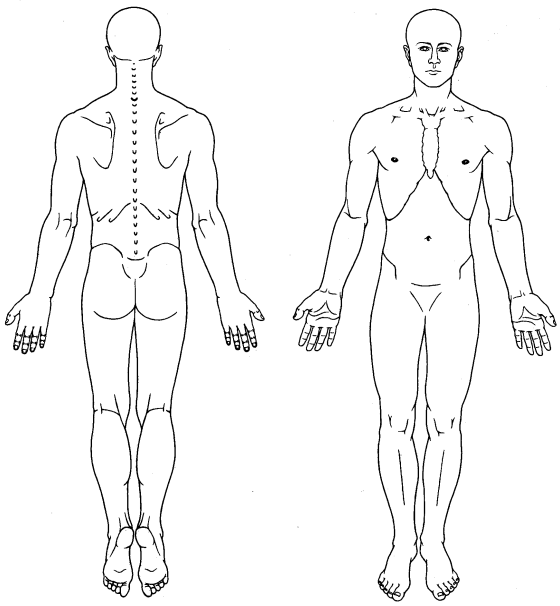
_____

Symptoms are worse in: ☐ morning ☐ afternoon ☐ night

Symptoms developed from: ☐ auto accident ☐ job related injury
☐ unknown cause ☐ Other _____

Symptoms are: ☐ constant ☐ come and go

Please mark where you are having pain



Type of pain:

☐ Aching ☐ Burning ☐ Cramps ☐ Dull ☐ Numbness ☐ Sharp ☐ Shooting ☐ Stiffness

☐ Swelling ☐ Throbbing ☐ Tingling ☐ Other _____

Symptoms have persisted for number of: **Onset date of injury:**_____

☐ Hours ☐ Days ☐ Weeks ☐ Months ☐ Years

Please check the following activities that aggravate your condition:

☐ Bending ☐ Coughing ☐ Lifting ☐ Lying down ☐ Reaching ☐ Sitting ☐ Sneezing ☐ Standing ☐ Walking

Please check the following activities that relieve your condition:

☐ Bending ☐ Coughing ☐ Lifting ☐ Lying down ☐ Reaching ☐ Sitting ☐ Sneezing ☐ Standing ☐ Walking

What treatment have you already received for your condition? _____

Are you taking any medications? ☐ Yes ☐ No If yes, what kind? _____

Women- Are you pregnant? ☐ Yes ☐ No If yes, what is your due date? _____

Please check any additional symptoms you are experiencing:

☐ Dizziness ☐ Headaches ☐ Loss of balance ☐ Muscle spasms ☐ Numbness ☐ Other _____

Check those conditions which you currently have or have had in the past:

☐ Cancer ☐ Diabetes ☐ Seizures ☐ Fractures ☐ Heart disease ☐ Herniated disc ☐ Migraines ☐ Osteoporosis

☐ Pacemaker ☐ Stroke ☐ Other _____

What type of exercise do you perform on a daily basis?

☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include?

☐ Sitting ☐ Standing ☐ Computer work ☐ Light labor ☐ Heavy labor ☐ Other _____

Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____

Dates of last exams: _____

Past surgeries: _____

Accident history: _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release my information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT (or parent if minor) Date

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INFORMED CONSENT

FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-ray, on me (or on the patient named below for whom I am legally responsible) by the doctor or intern affiliated with StoneRidge Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels, based on the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern affiliated with StoneRidge Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (Please Print) Date

Signature of Patient (Or Parent/Guardian If Minor)

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to see another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternate means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our private contact of your complaint. **We will not retaliate against you for filing a complaint**. This notice was published and becomes effective on/or before **April 14, 2003**. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and private practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the Main Phone Number. Signature below is only acknowledgement that you have received this Notice of our Privacy Policies:

Print Name: _____ Signature: _____

Date: _____